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Substance Abuse, Families, and the Courts

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SUBSTANCE ABUSE, FAMILIES, AND THE COURTS

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INTRODUCTION

When considering the dynamics of substance abuse metaphorically, the role of substance abuse within a family may best be considered along the lines of another family member. Its role is often comparable to that of a *relationship.* Other family members' regard for the usage may be antagonistic or familiar—if not positive. The relationship is rarely entirely neutral. The dynamics surrounding the usage frequently entail aspects of collusion, denial, family secrets, triangular communication, and typically involve issues of trust, or lack thereof.

A noteworthy and ever-growing percentage of family violence and child maltreatment cases entail parental substance abuse.[1] In cases involving substance-abusing women, questions of fetal exposure along with diminished parenting capabilities are necessarily pertinent in ways that were not as critically relevant when parental substance abuse was traditionally male-dominated.[2] Such factors necessarily influence the challenges faced by legal and social services responding to the current challenges of working with families with substance-abusing members.

Particularly complex legal, ethical, and psychosocial challenges are posed by cases of adolescent and maternal substance abuse, particularly when those cases involve substance abuse combined with other mental disorders.[3] Issues of multi-generational norms and behaviors are relevant. Questions of role models, learned behaviors, self-medication as well as perceived options may be superimposed upon elements of genetic predisposition and environment. Developmental as well as situational variables may further complicate the already complex role played by substance abuse in the lives of at-risk adolescents, women, and their families.

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1. *See infra* notes 36-40 and accompanying text.

2. *See* STEPHAN KANDALL, SUBSTANCE AND SHADOW: WOMEN AND ADDICTION IN THE UNITED STATES 258-59 (1996).

3. *See* Marsha Read et al., *Treatment for Dually Diagnosed Clients, in* SUBSTANCE ABUSE TREATMENT: A FAMILY SYSTEMS PERSPECTIVE 123, 141-42 (Edith Freeman, ed., 1993).

The role of families provides a defining context crucial to the consideration of substance abuse. When considering the role of substance abuse within families, variables such as environmental norms, expectations, and options arise, as well as issues of genetic predisposition and resilience. The family's response to substance abuse is a crucial variable in terms of treatment and prognosis. Likewise, the substance abuse also often defines many of the dynamics found in families affected by a member's usage.

Metaphorically, the role of substance abuse is perhaps best considered along the lines of a relationship. Whether the usage precedes or follows the parental relationship, it often functions as a metaphorical "third wheel." In accordance with a family systems conceptualization, the "triad" thus created necessarily entails some dynamic distortions and tension.

Part I of this Article discusses the family system model, including roles, lines of communication, homeostasis, and the impact of substance abuse on familial roles and the family system. Part II discusses the use of genograms in examining the impact of substance abuse on the family system. Part III examines specific at-risk populations, including adolescents and women, as well as how stereotyping and limited treatment options impact these special populations.

I. FAMILY SYSTEMS

For purposes of assessment and treatment planning, social workers often utilize a conceptualization of families which was developed for family practice.[4] Grounded in an ecological perspective, such a model views the family as a *system.*[5] A *system* refers to a unit that evolves with a potentially complex set of adaptive norms, rules, and functions.[6] Within the family system, there exist *subsystems,* which include marital and generational factors[7] and *hierarchies,* which entail the distribution of power.[8]

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4. *See* DEAN HEPWORTH ET AL., DIRECT SOCIAL WORK PRACTICE: THEORY AND SKILLS 276 (5th ed. 1997); *see generally* Edith M. Freeman, *Substance Abuse Treatment: Continuum of Care in Services to Families, in* SUBSTANCE ABUSE TREATMENT: A FAMILY SYSTEMS PERSPECTIVE (Edith M. Freeman ed., 1993); MURRAY BOWEN, FAMILY THERAPY IN CLINICAL PRACTICE (1978); Cloe Madanes & Jay Haley, *Dimensions of Family Therapy,* 165 J. NERVOUS & MENTAL DIS. 88 (1977); SALVADOR H. MINUCHIN, FAMILIES AND FAMILY THERAPY 52 (1974).

5. *See* HEPWORTH ET AL., *supra* note 4, at 277.

6. *See id.*

7. *See* MINUCHIN, *supra* note 4, at 52.

8. *See* HEPWORTH ET AL., *supra* note 4, at 295-99.

Establishing *boundaries*, both between members and the outside world, tends to be problematic.[9] The problems of poor boundaries often reflect either overly rigid or overly permeable boundaries. Problems of rigidity entail members becoming disengaged from one another, or from the external environment.[10] With overly permeable boundaries, enmeshment between members may occur, or the external boundaries between the family and the environment do not function adequately.[11] Metaphorically, the doors of the house are never locked. Governing *rules* which determine what works, are also relevant.[12] For example, is a parent's promise reliable when they are sober, but not when they are intoxicated? Behavioral rules may not apply when a parent is using, and be overly-applied when they are hung over.

Roles[13] are also established, as are lines of *communication.*[14] Roles may entail such factors as caregiving, or being sick, as well as enabling, provoking, or challenging a family member's usage.[15] Some children learn the safety of becoming "invisible" in substance-abusing families, and thus rarely confront others' behavior;[16] other children become aggressors in search of getting their needs met.[17] Still others may learn that by imitating a parent's or sibling's usage, they may attain a greater sense of connectedness than was otherwise available to them.

Lines of communication are strongly influenced by such rules as predictability and reliability.[18] For example, is it only safe to make requests of the user when they are using or when they are not using? Is it necessary to approach a parent through a third party? This would reflect the stereotypical "triangle" in which communication becomes a three-way rather than a two-way process.[19] When substance abuse is relevant, the usage may function as an implicit third party to family interactions.[20] The implications for how families find ways of solving

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9. *See generally id.* at 291-95 (describing the three categories of bonding arrangements and how each category has its own style in relating to the environment, as well as in relating to others within the family system).

10. *See id.* at 291.

11. *See id.* at 292-94.

12. *See id.* at 278-79.

13. *See id.* at 307.

14. *See id.* at 310.

15. *See id.* at 307-08.

16. *See* Claudia Black, *Innocent Bystanders at Risk: The Children of Alcoholics*, 1 ALCOHOLISM 22, 25 (1981).

17. *See id.*

18. *See* HEPWORTH ET AL., *supra* note 4, at 311-12.

19. *See* Madanes & Haley, *supra* note 4, at 94.

20. *See* Freeman, *supra* note 4, at 4.

problems are immense.[21] Without effective direct communication patterns, problems often evolve into crises before they are addressed.[22]

Particularly in cases involving substance abuse and dependence, issues of *secrets*, as well as trust and family *loyalties* are often dynamically important.[23] The role of secrets is a critical consideration in cases of substance abuse as well as in cases of families with histories of sexual abuse.[24] Often families develop either overt or covert rules about who is allowed to know what and when.[25] For example, illicit drug use may be kept a secret from the spouse, a parent, or the children, or the whole family may be aware of the behavior. Often the type of drug is relevant to such dynamics, as illicit drug use is often more likely to be kept a "secret" than is alcohol abuse.[26] There might be *collusion* within the family to maintain secrets. And disclosure of the usage may be regarded as disloyalty to the individual or family involved. If so, the consequences in the family for such disloyalty must be determined.

When one parent is drug-involved and the other is not, the tensions created typically revolve around conflicts over usage-related behaviors and financial strains.[27] When both parents are drug-involved, conflicts often shift focus to include questions of supply as well as issues of usage-related behaviors and financial strains.[28] In either scenario, children are often placed in a position of compensating for parental deficits and/or are left without a frame of reference for parental behavior other than those being modeled involving substance use and dependence.[29] In either scenario, such families are often at increased risk of being seen in various capacities in the legal system as a consequence of usage-related crises.[30] An important concern is whether there is someone who can and will consistently protect a child from the hazards of parental substance abuse-related behav-

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21. *See* HEPWORTH ET AL., *supra* note 4, at 276-77.

22. *See id.* at 310.

23. *See* Black, *supra* note 16, at 24-25.

24. *See id.*; *see also* Enid B. Young, *The Role of Incest Issues in Relapse and Recovery, in* PSYCHOTHERAPY AND SUBSTANCE ABUSE: A PRACTITIONER'S HANDBOOK 451, 452 (Arnold M. Washton ed., 1995).

25. *See* Black, *supra* note 16, at 24-25.

26. *See id.*

27. *See* PETER STEINGLASS ET AL., THE ALCOHOLIC FAMILY 46 (1987).

28. *See* Murray Bowen, *A Family Systems Approach to Alcoholism,* 21 ADDICTIONS 29, 30 (1974).

29. *See* Black, *supra* note 16, at 25.

30. *See* GEORGE E. VAILLANT, THE NATURAL HISTORY OF ALCOHOLISM REVISITED 28, 48, 97, 176 (1995).

iors.[31] Thus, legal as well as psychosocial professionals are increasingly required to be capable of responding to the personal and legal dilemmas created by substance abuse in an informed and constructive manner, which makes constructive interdisciplinary communication increasingly important for all concerned.[32]

Especially in cases of child maltreatment, questions of whether a child is functioning in the role of a "*scapegoat*" arise.[33] Dynamically, this occurs when a given member of a family occupies a consistent role in which his behavior is focused upon as the primary problem, serving to distract the attention away from another family member's behavior, such as drug involvement.[34] Often, the "scapegoat" child is the identified problem, such as the truancy case, or the runaway.[35] Therefore, as long as the legal system remains distracted by the child's behavior at the expense of looking at the familial context, including the potential for drug involvement, the family's substance usage can remain unchallenged and unchanged.[36]

Homeostasis is still another family systems concept with particular relevance to families with substance-abusing members.[37] Reflected by the family's inherent efforts to maintain stability and predictability, the status quo, homeostasis typically entails resistance to change.[38] Families facing various illnesses, or other threats to their integrity, typically develop remarkable adaptive functions. In response to substance abuse, as is often the case with other chronic and potentially fatal diseases, families find ways in which to adapt to the financial, social, legal, and medical challenges involved.[39] How constructive or destructive their adaptive strategies may be varies considerably, but still necessitate professionals' appreciation and respect as survival techniques intended to respond to a serious threat.[40]

Within a *family systems* conceptualization, the substance use occurs within the context of the family constellation.[41] By definition, the us-

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31. *See* Black, *supra* note 16, at 23.

32. *See id.*

33. *See* MINUCHIN, *supra* note 4, at 98.

34. *See id.*

35. *See id.*

36. *See id.* at 52.

37. *See* STEINGLASS ET AL., *supra* note 27, at 50-52.

38. *See id.*

39. *See generally id.* at 69-73 (describing factors which affect families dealing with alcoholics and how families adapt).

40. *See generally id.* at 49-73 (describing family homeostasis and regulating behaviors in the alcoholic family).

41. *See id.*

age does not occur in a vacuum; it occurs in a context.[42] Change also occurs as a systemic process, rather than as an isolated event.[43] Within a family systems conceptualization, change is seen as being more circular than linear, thus involving the whole rather than just the parts or members.[44] While the response of other family members varies, certain themes may become characteristic of the family's responses.[45] It may be a multi-generational norm and possibly minimized, it may be kept strictly secret, or it may be quietly enabled. Whatever the response, the family context typically provides the environmental references which both influence and shape the consequences of usage.[46]

II. GENOGRAMS

The use of genograms can provide a very efficient tool for considering cases of families with substance abuse problems.[47] Genograms provide a systematic means of diagramming a family constellation, using specific symbols to indicate gender, structure, and relationships.[48] An example is provided in Table One. In Table Two, a revised genogram is suggested in which the substance abuse itself is also included as a family member. Although this is not necessarily the traditional usage of the genogram format, it may provide a visual tool with which to offer a diagramatic representation of the role of substance abuse.[49]

Especially in cases involving substance abuse, the family patterns of usage may prove informative, with specific substances being preferred over others.[50] In some cases, the use of colors to indicate drugs of choice may prove helpful to distinguish patterns (e.g., specific colors to distinguish street drugs from alcohol or prescriptions, etc.).

Along with providing a visual tool for distinguishing substance and legal patterns, genograms may also offer a means of observing family patterns of other conditions, such as diabetes, depression, and schizophrenia.[51] Family patterns such as violence, sexual abuse, and

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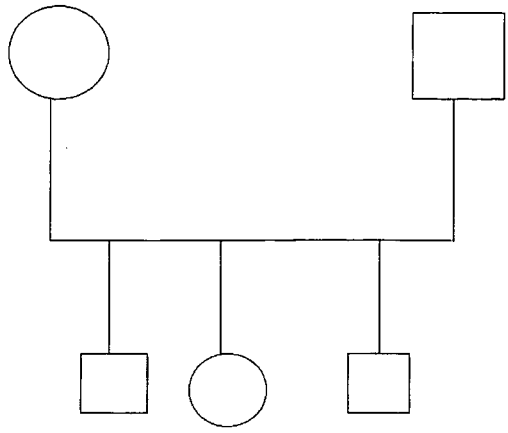
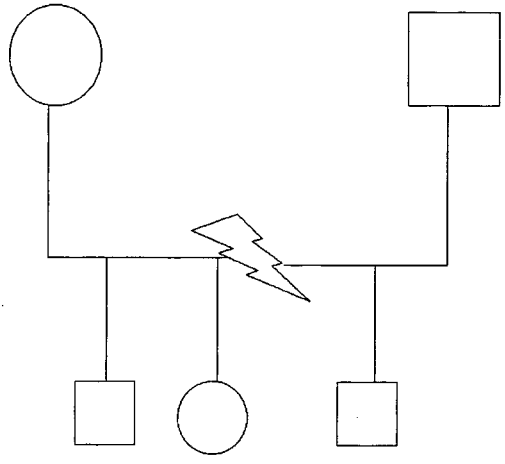
42. *See id.*
43. *See id.* at 76-77.
44. *See id.* at 77.
45. *See id.* at 81.
46. *See id.*
47. *See* MONICA MCGOLDRICK & RANDY GERSON, GENOGRAMS IN FAMILY ASSESSMENT 76 (1985).
48. *See id.* at 9-10.
49. *See generally id.* at 35-38, 76.
50. *See id.* at 76.
51. *See id.* at 139.

TABLE ONE



Key: Circles represent females
Squares represent males
Horizontal lines represent marriage
"X" through a figure represents death
Lightning bolt represents usage

TABLE TWO



suicide may also become evident.[52] Generally, the use of specific birth dates rather than ages seems to simplify the use of genograms.[53] For example, in recognizing family patterns of teenage mothers, or paren-

52. *See id.* at 76.
53. *See id.* at 10.

tal deaths during childhood, specific birth dates help clarify such details.[54]

III. SPECIFIC AT-RISK POPULATIONS

Despite some of the commonalities noted among families with substance-abusing members, there are some populations who pose particular challenges to providers of psychosocial and legal services. For the purposes of this consideration, the populations of concern are adolescent substance abusers, female (particularly maternal) substance abusers, and substance abusers with co-existing psychiatric conditions.

A. Adolescents

Providers of psychosocial and legal services need to be particularly mindful of the developmental distinctions between experimental versus habitual usage of substances.[55] The majority of adolescents will predictably experiment at some time with illicit substances.[56] A relatively small minority proceed to actual chemical dependence.[57] Nonetheless, the implications of drug-related, high-risk behavior must not be minimized.[58] Adolescents with family histories and a genetic predisposition for substance abuse must be carefully considered accordingly.[59]

Developmental questions feature prominently among the many challenges presented by adolescent substance abusers.[60] In cases in which adolescents are abusing substances, either in-patient treatment or placement outside their family of origin may be indicated. In such cases, providers of legal or psychosocial services frequently find that protective services available for adolescents are lacking when com-

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54. *See id.* at 13-14, 24.

55. *See* Jonahan Shedler & Jack Block, *Adolescent Drug Use and Psychological Health: A Longitudinal Study*, 45 AM. PSYCHOLOGIST 612, 627-28 (1990).

56. *See* Thomas P. Gullotta & Gary A. Blau, *A Select Social History of the Psychoactive Drugs: Tobacco, Alcohol, Marijuana, Cocaine, and Heroin, in* SUBSTANCE MISUSE IN ADOLESCENCE 11-13 (Thomas P. Gullotta et al. eds., 1995); *see also* Trina M. Anglin, *Psychoactive Substance Use and Abuse, in* HANDBOOK FOR SCREENING ADOLESCENTS AT PSYCHOSOCIAL RISK 41, 43-45 (M. Singer et al. eds., 1993).

57. *See* Shedler & Block, *supra* note 55, at 613.

58. *See* Anglin, *supra* note 56, at 41-42.

59. *See* E. Norman, *Personal Factors Related to Substance Misuse: Risk Abatement and/or Resiliency Enhancement?, in* SUBSTANCE MISUSE IN ADOLESCENCE 15-16 (Thomas P. Gullotta et al. eds., 1994).

60. *See* Robert Margolis, *Adolescent Chemical Dependence: Assessment, Treatment and Management, in* PSYCHOTHERAPY AND SUBSTANCE ABUSE, A PRACTITIONER'S HANDBOOK 394, 410 (Arnold M. Washton ed., 1995).

pared either with those available for younger children or resources available for adults.[61] Even when such resources are available, in-patient treatment remains an under-utilized treatment approach for adolescents, particularly among ethnic minorities.[62]

When pursuing available options for in-patient care, available slots for adolescents are frequently limited.[63] In-patient admissions also entail parental or a guardian's consent, as well as family involvement in the proposed treatment regimen.[64] Such participation is not always readily forthcoming, as adolescents may not have family members sufficiently involved or equipped for the expenses involved.[65] Further problems may arise when dealing with parents who themselves are substance abusers. In such cases, the parents may be disinterested in intensive scrutiny of their teenager's usage patterns.[66]

In cases involving custody or guardianship questions, adolescents may also "fall between the cracks" of the available system.[67] Social and legal services have traditionally presumed that children and adolescents have the advantage of two parents each. Such presumptions are no longer necessarily applicable. In cases in which a single parent has no legal or financial support from the child's other parent, or when one or both parents are themselves so drug-involved as to compromise their parental functions, children are at particular risk.[68] Ironically, for adolescents, the subsequent prospects of placement with foster care resources may again be considerably more limited than those options available for younger children.

In considering the psychosocial and legal services needed by adolescent substance abusers, three themes demand careful attention: the role of trauma, the role of poverty, and the potential for self-medica-

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61. *See* Anand Chabra et al., *Hospitalization for Mental Illness in Adolescents*, 24 J. ADOLESCENT HEALTH 349, 351-55 (1999).

62. *See id.* at 353-55.

63. *See* NATIONAL CENTER ON ADDICTION AND SUBSTANCE ABUSE AT COLUMBIA UNIVERSITY, NO SAFE HAVEN: CHILDREN OF SUBSTANCE-ABUSING PARENTS 2 (1999) [hereinafter CASA, NO SAFE HAVEN].

64. *See* Margolis, *supra* note 60, at 394-412.

65. *See* Edith Freeman, *Developing Alternative Family Structures for Runaway, Drug-Addicted Adolescents, in* SUBSTANCE ABUSE TREATMENT: A FAMILY SYSTEMS PERSPECTIVE 60 (Edith M. Freeman ed., 1993).

66. *See id.* at 60; *see also* Freeman, *supra* note 4, at 11.

67. *See generally* Anglin, *supra* note 56, at 67-77 (discussing counseling strategies and treatment available for adolescents with substance abuse problems).

68. *See* HAROLD I. KAPLAN & BENJAMIN J. SADOCK, SYNOPSIS OF PSYCHIATRY: BEHAVIORAL SCIENCES/CLINICAL PSYCHIATRY 383-84 (8th ed., 1998).

tion in the lives of teenagers.[69] When considering the role of trauma, providers of services must be mindful of a teenager's personal history.[70] For example, have they been subjected to physical or sexual abuse?[71] If so, substance abuse may represent a form of self-medication to manage post-traumatic symptoms.[72] Have they witnessed domestic or random violence?[73] Have they experienced bereavement or dislocation?[74]

Useful questions to ask adolescents are: "Prior to this [the current crisis], what is the worst time you have ever experienced? And what helped you through that bad time?" Such information may not only provide a sense of what is normal for the teenager, but also what resources, such as family, friends, or religious faith, were seen as either supportive or irrelevant in the past. The coping strategies which helped in the past are likely to be used again, and adolescents often respond positively to an adult's expression of admiration for their prior effectiveness at coping with difficulties.

On the other hand, when a teenager has a history of responding to difficulties with alcohol or drugs, they may expect to continue along such routes of pseudo-problem solving.[75] Further issues of developmental arrests associated with the onset of substance use demand close attention with adolescents. Teenagers involved with substance abuse will typically present with deficient social and problem-solving skills, and impulse-control deficits when compared with their non-using counterparts of the same age.[76]

A particularly disturbing and difficult-to-reach subgroup of adolescents who may also frequent the court system are those who are homeless or are runaways. In many such cases, the adolescent's status was not voluntarily chosen, but is a result either of familial rejection or disruption.[77] Substance-abuse problems are frequently seen among the homeless population.[78] More disturbing, however, are estimates

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69. *See* Beth Glover Reed, *Linkages: Battering, Sexual Assault, Incest, Child Sexual Abuse, Teen Pregnancy, Dropping Out of School and the Alcohol and Drug Connection, in* ALCOHOL AND DRUGS ARE WOMEN'S ISSUES 130, 138-40 (Paula Roth ed., 1991).

70. *See* Patricia A. Harrison et al., *Multiple Substance Use Among Adolescent Physical and Sexual Abuse Victims*, 21 CHILD ABUSE & NEGLECT 529, 536-38 (1997).

71. *See id.* at 536; *see also* Reed, *supra* note 69, at 139.

72. *See* Harrison, *supra* note 70, at 536; *see also* Reed, *supra* note 69, at 139.

73. *See* Harrison, *supra* note 70, at 536.

74. *See id.*

75. *See id.*

76. *See id.* at 537; *see also* Freeman, *supra* note 65, at 54.

77. *See* HEPWORTH ET AL., *supra* note 4, at 467-68; *see also* Freeman, *supra* note 65, at 48, 50.

78. *See* Freeman, *supra* note 65, at 53.

that women and children comprise twenty-five percent or more of the homeless population.[79] The average age for runaway adolescents is fifteen and they are twice as likely to be female than male.[80] The financial as well as social realities of being a runaway or homeless adolescent pose life-threatening risks, which include drug running or dealing as well as prostitution.[81] Drug-related activities represent not only a means of financial survival, but may also reflect a means of acquiring social relations, along with being a means of self-medication or numbing.[82] Meanwhile, homeless or runaway adolescents, because of their age, are subject to status offences and often enter the juvenile justice system prior to entering therapeutic treatment facilities equipped to address their medical and psychosocial needs.[83]

The role of poverty in the lives of substance-abusing adolescents is a critical distinction for many treatment decisions and outcomes.[84] Among the various risk factors associated with adolescent substance abuse, poverty is a considerably more potent risk factor for substance abuse than ethnicity.[85] Specifically in cases of urban poverty, an adolescent substance abuser is more likely than his or her more affluent counterpart to be prosecuted than to receive treatment for the substance abuse.[86] Adolescents surviving in urban poverty are also more likely to see substance abuse more overtly sanctioned among role models—both as a means of coping as well as a means of becóming financially independent.[87]

The lure of drug-related money, along with the glamour and status associated with "the street" can prove overwhelming, especially in cases in which adolescents do not see traditional education as a viable option.[88] Consistently higher rates of illicit drug use have been documented among young adults ages eighteen to twenty-four who did not complete high school.[89] Clearly, "chicken vs. egg" questions arise when considering whether the drug use precipitated the educational crisis or vice versa.

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79. *See* KANDALL, *supra* note 2, at 258-59.
80. *See* Freeman, *supra* note 65, at 51.
81. *See id.* at 53-56.
82. *See id.*
83. *See id.* at 50, 56-58.
84. *See id.* at 55; *see also* Sandra Turner, *Family Variables Related to Adolescent Substance Misuse: Risk and Resiliency Factors, in* SUBSTANCE MISUSE IN ADOLESCENCE 41 (Gullotta et al., 1994).
85. *See* Turner, *supra* note 84; *see also* CASA, NO SAFE HAVEN, *supra* note 63, at iii.
86. *See* Freeman, *supra* note 65, at 53.
87. *See id.* at 55-56.
88. *See id.*
89. *See* KAPLAN & SADOCK, *supra* note 68, at 383-84.

While policy makers refer to inner-city "war zones,"[90] the reality of children and adolescents who live there and the survival strategies necessary for their self-preservation often go unconsidered. Unfortunately, teenagers coming through the court systems from such environments are frequently seen stereotypically. Their behavior is regarded by society as delinquent instead of desperate.[91] Drug-driven anti-social behavior represents a more easily defined problem than the nonetheless treatable condition of substance abuse or dependence.[92] Variables—such as options, role models, and coping mechanisms—demand careful consideration in planning a constructive response to this profoundly troubled and troubling population.

A final consideration relevant to the role of substance abuse in the lives of adolescents involves the use of substances for self-medication purposes. Teenagers need to be screened for co-morbid conditions such as depression, bipolar disorder, Post-Traumatic Stress Disorder (PTSD), as well as co-addiction.[93] Especially in cases of trauma such as sexual abuse, assault, violence and bereavement, professionals must be attuned to the utility of substances for purposes of numbing intrusive memories or feelings of loss and sadness.[94] Family histories of mood disorders, including both depression and bipolar, also justify screening adolescents for complicating psychosocial factors relevant to treatment planning.

Ideally, responses to such adolescents should be designed to address corrective and curative efforts, rather than directing such youth toward lifetime histories of criminal and institutionalized roles. By emphasizing assessment and treatment prior to penalization, professionals have the means of preventing further harm to some profoundly vulnerable youth.

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90. *See* Freeman, *supra* note 65, at 49.

91. *See* Patricia A. Pape, *Issues in Assessment and Intervention with Alcohol-and-Drug-Abusing Women, in* CLINICAL WORK WITH SUBSTANCE-ABUSING CLIENTS 251, 261 (Shulamith Straussner ed., 1993) (summarizing the results of an American Medical Association (AMA) study which illustrated that the public perceived drinking among alcoholics and drug use by addicts resulting from choice, lack of willpower, and moral weakness).

92. *See* Anglin, *supra* note 56, at 41.

93. *See* KAPLAN & SADOCK, *supra* note 68, at 384; *see also* Anglin, *supra* note 56, at 46-83; Freeman, *supra* note 65, at 58.

94. *See* Anglin *supra* note 56, at 42; *see also* Freeman *supra* note 65, at 49; Robert Fahnestock, *The Impact of Substance Abuse and Post-Traumatic Stress Disorder, in* SUBSTANCE ABUSE TREATMENT: A FAMILY SYSTEMS PERSPECTIVE 157 (Edith Freeman ed., 1993) (defining psychic numbing as the blocking or numbing of troublesome memories and emotions).

B. Women and Substance Abuse

Of the demographic patterns of substance abuse, those for women are among the most disturbing. The large majority of illicit drug use among women occurs among women who are of childbearing age.[95] Recent estimates place the rate of illicit drug use within the past month among women ages 15-44 at 7.3%, a total of 4.3 million women.[96] Those numbers do not reflect the rate of alcohol abuse or dependence, or the rate of prescribed drug abuse among women.[97] Of the 4.3 million women abusing or dependent upon illicit drugs, more than 1.6 million have custody of children, including nearly 400,000 with at least one child under the age of two years.[98] Meanwhile, the occurrence of a substance abuse disorder at least triples the risk of child maltreatment. Recent estimates place the incidence of substance abuse in families involved in the child welfare system at up to 80%.[99]

Because family problems related to substance abuse have traditionally resulted from male drinking, the relatively recent demographic shift toward maternal illicit drug dependence has profound implications for providers of legal as well as psychosocial services.[100] As with adolescent substance abuse, women with drug problems are often perceived stereotypically,[101] and their substance abuse is subject to legal and political repercussions rather than clinical assessment and intervention. Ironically, the health implications for substance-abusing women, including malnutrition, fetal exposure, STDs and HIV/AIDS,[102] which are profoundly important to their children, are often left unaddressed by the legal as well as the social welfare system.

As with adolescents, female substance abuse typically reflects complex constellations of genetic influences as well as trauma, poverty, and co-morbid psychiatric conditions.[103] In addition to such complications, however, substance-abusing women are also particularly vulnerable to domestic violence, especially at the hands of sub-

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95. *See* KAPLAN & SADOCK, *supra* note 68, at 383 (noting that 7.3% of women of childbearing age use illicit drugs while only 4.5% of women overall do).

96. *See id.*

97. *See id.*

98. *See id.*

99. *See* CASA, NO SAFE HAVEN, *supra* note 63, at 13.

100. *See* Reed, *supra* note 69, at 135, 142.

101. *See* KANDALL, *supra* note 2, at 285; *see also* Barbara Lex, *Prevention of Substance Abuse Problems in Women, in* DRUG AND ALCOHOL ABUSE PREVENTION 167, 169-70 (Ronald Watson ed., 1990); *see also* Pape, *supra* note 91, at 251, 261; Reed, *supra* note 69, at 141.

102. *See* KANDALL, *supra* note 2, at 258-59.

103. *See* Lex, *supra* note 101, at 170-73.

stance-abusing partners.[104] The focus of this consideration will primarily be on issues of prior trauma, co-morbid conditions, and relationship issues.

As with adolescents, the role of childhood sexual abuse as a precedent to substance abuse among women has been well established.[105] The powerful role of sexual trauma as a triggering factor however, is often disregarded as a life-altering variable.[106] The woman's subsequent behavior, choice of partners, and means of self-medicating are often equated with a willful moral failure, rather than reflections of childhood trauma. When substances are utilized in conjunction with sexual activity, women with childhood abuse histories are at particular risk of an especially "vicious circle" with substance-abusing partners, and the exchange of sex for drugs.[107]

The social stigma associated with women's intoxication remains greater than that for men.[108] Such a historical discrepancy is also reflected in the lack of treatment slots available for chemically-dependent women seeking in-patient care.[109] While the role of PTSD with combat veterans suffering with substance abuse is well-established,[110] substance-abusing women with PTSD symptoms are not necessarily recognized with the same sympathy. Issues such as relationship and employment difficulties, or emotional instability among substance-abusing women are not necessarily viewed with the same consideration given to combat veterans manifesting the same features. Given the correlation between multiple traumas, especially trauma at a young age, and subsequent features of PTSD, as well as substance abuse, women with substance abuse histories warrant screening for childhood trauma in order to direct psychosocial as well as legal services accordingly.[111]

Mood disorders may further complicate substance-abusing women's psychosocial and legal circumstances. Although depression is

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104. *See* Margaret Goldberg, *Substance-Abusing Women: False Stereotypes and Real Needs*, 40 SOC. WORK 789, 792 (1995); *see also* Pape, *supra* note 91, at 258.

105. *See* Goldberg, *supra* note 104, at 792; *see also* Pape, *supra* note 91, at 253; Reed, *supra* note 69, at 139.

106. *See* Young, *supra* note 24, at 452.

107. *See* KANDALL, *supra* note 2, at 247; *see also* Lex, *supra* note 101, at 202.

108. *See* Goldberg, *supra* note 104, at 792; *see also* Reed, *supra* note 69, at 134, 138.

109. *See* KANDALL, *supra* note 2, at 271; *see also* Barbara C. Wallace, *Women and Minorities in Treatment, in* PSYCHOTHERAPY AND SUBSTANCE ABUSE: A PRACTITIONER'S HANDBOOK 470, 471 (Arnold M. Washton ed., 1995).

110. *See generally* Fahnestock, *supra* note 94, at 157, 158, 163, 167, 183 (comparing the life of alcoholics and their PTSD to that of Vietnam Veterans).

111. *See* KANDALL, *supra* note 2, at 290-91; *see also* Reed, *supra* note 69, at 141; Young, *supra* note 24, at 456.

more commonly noted among women substance abusers than among their male counterparts, again questions arise about which came first: the mood disorder or the substance abuse.[112] The difficulties inherent in distinguishing between the effects of drug-related mood swings and actual mood disorders further complicate assessment and treatment efforts.[113] Particularly with bipolar disorder, the mood disorder symptoms are easily confused with drug-related behaviors,[114] especially when a cocaine high closely resembles a manic episode. The risks of suicide among substance-abusing populations are an ongoing assessment issue;[115] among women, particularly those who are opiod dependent, risks of suicide especially by overdose must be taken seriously.

Alcohol-abusing women have consistently been found to have a higher rate of divorce than their alcohol-abusing male counterparts.[116] Specifically, husbands are more likely to divorce alcohol-dependent wives than vice versa.[117] These findings persist, despite the consistent findings that female abusers are more likely than male abusers to be with partners who also abuse substances.[118]

Women with substance abuse problems also have a heightened risk of being victimized by domestic violence.[119] While there is no conclusive data establishing substance abuse as the actual cause of domestic violence, both heterosexual and homosexual partnerships entail heightened risks of violence against substance-abusing women.[120] For women, inebriation remains a primary deterrent to seeking or receiving shelter,[121] thus raising questions of safety for herself and her children, and escalating violence.

Seeking help under violent circumstances can be very frightening, and potentially dangerous.[122] For providers of legal and psychosocial services, the establishment of safety must remain the top priority for the woman and any children in the home.[123] Particularly when financial vulnerabilities place women and children at heightened risks, professionals must take particular care to avoid perpetuat-

112. *See* Pape, *supra* note 91, at 261-62.
113. *See* Read, *supra* note 3, at 136.
114. *See id.* at 135.
115. *See* KAPLAN & SADOCK, *supra* note 68, at 385-86.
116. *See* Goldberg, *supra* note 104, at 792.
117. *See id.*; *see also* Pape, *supra* note 91, at 258.
118. *See* Lex, *supra* note 101, at 171.
119. *See* Goldberg, *supra* note 104, at 792; *see also* Pape, *supra* note 91, at 258.
120. *See* Pape, *supra* note 91, at 258.
121. *See id.*
122. *See* Reed, *supra* note 69, at 147.
123. *See id.*

ing a system which often "blames the victim."[124] Ideally, the substance-abusing woman and her partner will seek intervention that encompasses substance abuse issues as well as anger management and avoidance of violence.[125] Group work and education are typically beneficial for both partners.[126]

CONCLUSION

The challenges of meeting the needs of families with substance-abusing members have changed in the past two decades. Youthful onset of usage has added some unprecedented challenges to prospects of "rehabilitation" among a population needing services who may never have had opportunity for "habilitation" in the first place. Increased maternal usage of illicit drugs has added an ominous dimension to the chronic levels of chaos and crisis associated with parental substance abuse.

Providers of legal and psychosocial services must remain alert to signs and symptoms of substance abuse among the populations they serve. They must also maintain an awareness of the inherent association between various substance abuse-related behaviors and the risks of criminality. Professionals are increasingly called upon to forge interdisciplinary alliances in the best interest of the populations they seek to serve. Through familiarity with available resources, such as out-patient, self-help, twelve-step as well as in-patient care, along with the existing family and child welfare resources, professionals are better equipped to address the increasingly complex needs of those individuals and families who suffer with substance abuse problems.

124. *See id.* at 134; *see also* Pape, *supra* note 91, at 260.
125. *See* Pape, *supra* note 91, at 263; *see also* Reed, *supra* note 69, at 146-47.
126. *See* Pape, *supra* note 91, at 263.